Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 25, 2017	2016_389601_0034	029291-16	Complaint

Licensee/Titulaire de permis

St. Joseph's at Fleming
659 Brealey Drive PETERBOROUGH ON K9K 2R8

Long-Term Care Home/Foyer de soins de longue durée

ST JOSEPH'S AT FLEMING
659 Brealey Drive PETERBOROUGH ON K9K 2R8

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

KARYN WOOD (601)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): November 29, 30 and December 1, 2, 5, 6, 7, 13, 14, 19, 20, 2016.

Log #029291-16 related to falls management and resident care.

LTCHA s. 6(7) was found to be in non-compliance and a VPC will be issued under Inspection Report 2016_272647_0017.

During the course of the inspection, the inspector(s) spoke with a resident, a family member, the Chief Executive Officer (CEO), the Director of Care (DOC), Unit Managers (UM), the Nurse Practitioner, Physiotherapist (PT), Physiotherapist Assistant (PTA), Pharmacist, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), and Maintenance Worker.

The Inspector also observed interactions between staff to residents, reviewed resident health care records, the licensee's investigation documentation, and the licensee policies related to complaints and falls.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Personal Support Services
Reporting and Complaints
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in accordance with manufacturers' instructions related to resident #001's identified care equipment.

During a telephone interview, the complainant indicated to Inspector #601 that resident #001's identified care equipment was unsteady and was not safe. The complainant also indicated to Inspector #601 that resident #001 had an unsteady gait, was not aware of limitations and would attempt to use the care equipment without staff assistance. During the same interview, the complainant indicated that resident #001 was recently found on the floor. The complainant indicated to Inspector #601 that there was a safety concern about resident #001's care equipment and the stability of the care equipment was discussed with staff at a recent care conference. The complainant indicated that the Chief Executive Officer (CEO) had sent an email response to the complaint and the complainant was not happy that nothing could be done about the care equipment safety.

On December 14, 2016, Inspector #601 reviewed the email documentation sent to the complainant on an identified date and time by the CEO that indicated the Nurse Manager and the Environmental Manger had determined that resident #001's care equipment was safe and specifically designed to meet industry standards.

On December 14, 2016 at approximately 0845 hour, Unit Manager (UM) #101 provided Inspector #601 with the manufacturer instructions of the care equipment. Inspector #601 reviewed the manufacturer instruction provided by UM #101 and noted that figured one illustration of the care equipment being used by resident #001 required an identified part to support the equipment. On December 14, 2016 at approximately 0845 hour, UM #101 and Inspector #601 observed resident #001's care equipment and noted that the part required to support the care equipment was missing.

During an interview at this time, UM #101 indicated not being aware that the identified support for the care equipment was missing. During the same interview, UM #101 indicated that resident #001's care equipment should have the support in place to meet the manufacturer instructions.

On December 14, 2016, Inspector #601 reviewed the care equipment's manufacturers assembly instructions and precautions sheet and identified that users with limited physical strength should be supervised or assisted while using the care equipment.

During an interview on December 14, 2016 at approximately 0845 hour, UM #101 indicated to Inspector #601 that resident #001 does not always ask for staff assistance prior to using the care equipment due to cognitive impairment.

Inspector #601 reviewed resident #001's current care plan and identified that resident

#001 had physical limitations and required one staff assistance to use the care equipment, high risk for falls and would use the care equipment independently at times related to cognitive impairment.

Inspector #601 reviewed resident #001's progress notes on December 14, 2016 and identified that on an identified date and time resident #001 had been found on the floor.

On December 14, 2016, Inspector #601 reviewed resident #001's MORSE Fall Assessment. The MORSE Fall Assessment indicated that resident #001 had a history of falls, used an ambulatory aid and had a weak gait, overestimates abilities due to cognitive impairment.

During an interview on December 14, 2016 at approximately 0845 hour, UM #101 indicated to Inspector #601 that resident #001 had decreased physical strength and used the care equipment at times without staff assistance related to cognitive impairment. Inspector #601 reviewed and identified that resident #001's care equipment's manufacturers assembly instructions and precautions sheet indicated that users with limited physical strength should be supervised or assisted while using the care equipment. [s. 23.]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a record was kept of the date, the participants, and the results of resident #001's annual care conference of the interdisciplinary team discussion regarding resident #001's plan of care and any other matters of importance to the resident and his or her Substitute Decision Maker (SDM).

Review of resident #001's clinical health records by Inspector #601 identified that resident #001 had a SDM in place for personal care decisions.

During a telephone interview, resident #001's SDM indicated to Inspector #601 that they were not invited to the resident's annual care conference in 2015.

Inspector #601 reviewed resident #001's progress notes on December 13, 2016 regarding annual care conferences for resident #001 and identified that there was a record of an annual care conference for the years 2013, 2014, 2016, and there was no documented record of an annual care conference for 2015.

During an interview on December 13, 2016, Unit Manager #101 indicated to Inspector #601that it was identified that resident #001 did not receive an annual care conference in the year 2015. Unit Manager #101 indicated that there was a change in the homes process during that period of time and resident #001 was not scheduled an annual care conference in the year 2015. [s. 27. (1)]

Issued on this 31st day of January, 2017

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.